February 22, 2002
FQHCs and RHCs
MONTANA MEDICAID NOTICE

On September 24, 2001, DPHHS changed the payment methodology for RHCs and FQHCs to a Prospective Payment System (PPS). PPS uses one all-inclusive payment rate per patient visit. Other ambulatory and incident-to services are included in this rate and, in most cases, are no longer separately billable. Clinics and centers are limited to revenue codes 521 RHC clinic visit, 529 FQHC clinic visit, 522 Visiting Nurse (you must be a HPSA designated shortage area to use this), 420 Physical therapy and 512 Dental visit.

You will receive the same rate per visit regardless of the procedure or diagnosis code. You will be limited to one visit and one unit of service per day, with the exception of a separate mental health and/or dental visit. Span billing is not allowed for RHC/FQHC services. You may bill for one date of service per claim.

A visit is defined as a **face to face** encounter between a RHC/FQHC patient and a RHC/FQHC health professional for the purpose of providing RHC/FQHC core, other ambulatory services or billable incident-to services. RHC/FQHC health professionals are physicians, dentists, nurse practitioners, physician assistants, nurse-midwives, nurse specialists, clinical psychologists, clinical social workers and licensed professional counselors.

Encounters with more than one RHC/FQHC health professional, and multiple encounters with the same RHC/FQHC health professional on the same day at a single location constitute a single visit except when one of the following exists:

- ✓ after the first encounter, the patient suffers an additional illness or injury requiring additional diagnosis or treatment; or
- ✓ the patient has a medical visit and a mental health visit, or a medical visit and a dental visit or a mental health visit and a dental visit.

Claims for multiple visits on the same day must be sent, on a completed UB-92, to the Hospital & Clinic Section of Health Policy and Services Division for review. Do not send to ACS.

To assist you with these changes to your billing methodologies, the Department is enclosing a Billing Guide for your provider type. This guide supercedes all other Prospective Payment billing guides for FQHCs and RHCs and should be kept with your September 2001 manual.

If you have any questions or require additional information, please call Provider Relations at:

Helena and out-of-state: 406-442-1837
In-state toll-free: 800-624-3958

FQHC Providers

The attached billing guide dated February 22, 2002, supercedes all other billing guides for the Montana Medicaid Prospective Payment System. Please keep this guide with your Montana Medicaid Provider Manual dated September 2001.

(For claim dates of service starting January 1, 2001)

FQHC CORE SERVICES

Unless otherwise noted, only the following services may be billed as a FQHC visit:

- Physician
- Nurse Practitioner
- Physician Assistant
- Nurse-midwife
- Nurse Specialist
- Clinical Psychologist
- Clinical Social Worker
- Licensed Professional Counselor
- Dentist

  - Basic core visits are billed on a UB-92 using Revenue Code 529.
  - Any other services, such as laboratory or radiology (even if performed on another day) are considered incident-to-services and are all-inclusive in the rate you are paid for the visit with the core provider.

- The following incident-to-services may be billed as a stand-alone visit on a UB-92 using Revenue Code 529 provided they are administered by a core provider or an RN (under the close personal supervision of a physician):

  - X Pneumococcal and influenza vaccinations and administration.
  - X Contraceptive injections (such as Depo-Provera).

- Dental hygienist services may be billed as stand-alone visit on a UB-92 using Revenue Code 512 provided they are performed by a licensed dental hygienist (under the direct personal supervision of a licensed dentist).

Billable Preventive Primary Services are billed on a UB-92 using Revenue Code 529 and include the following:

- X Perinatal care for high risk patients
- X Tuberculosis testing for high risk patients
- X Risk assessment and initial counseling regarding risks
- X Targeted Case Management (RN or core provider only)

- Visiting Nurse Services are billed under Revenue Code 522. You must be a designated HPSA Home Health Shortage Area.

- Billable other ambulatory services are billed on a UB-92 using Revenue Code 529 (unless otherwise noted) and include the following:

- Respiratory therapy and inhalation therapy. Service are covered for children age 20 and upon written physician referral (please refer to the EPSDT Medicaid Provider Manual).
- Physical therapy (revenue code 420). Only restorative physical therapy, which is reasonable and necessary to the treatment of the recipient's illness or injury, will be reimbursed by the Montana Medicaid program upon written physician referral (good for only 180 days). Services are limited to 70 hours per state fiscal year from all sources and require PASSPORT pre-authorization. You must contact the Department to be set up as a physical therapist provider.
- Occupational therapy means the use of purposeful activity with an individual who is limited by physical injury or illness, psychosocial dysfunction, developmental or learning disability, or the aging process in order to maximize independence, prevent disability, and maintain health. Only restorative therapy, which is reasonable and necessary to the treatment of the recipient's illness or injury, will be reimbursed by the Montana Medicaid program upon written physician referral (good for only 180 days). Services are limited to 70 hours per state fiscal year from all sources and require PASSPORT pre-authorization.
- Audiology Services are limited to hearing aid evaluation (HAE) and basic audio assessment (BAA) provided by a licensed audiologist, upon physician referral, to individuals with hearing disorders.
- Dental services must be provided by a licensed dentist or by a licensed dental hygienist (under the direct supervision of a licensed dentist). The services must be within the scope of their profession, as defined by law. These services must be billed on a UB-92 using revenue code 512. All applicable Montana Medicaid rules apply. Please see the Montana Medicaid Dental Provider Manual for covered services.
- Mental Health Services. Please see the Montana Medicaid Mental Health Provider Manual for covered billable services. Covered services provided in a FQHC must be billed on a UB-92 using revenue code 529 and the primary diagnosis code must be a valid mental health code.

< Incident-to services performed by non-core providers (lab techs, radiologist, LPN, CMA, etc.) are included in your PPS rate and are not billable as a stand-alone visit even if the service is performed on a separate day from the core visit. The following services are included in your PPS rate and are not considered a face-to-face visit when they are the only service performed. **These may not be billed as a stand-alone visit under ANY revenue code including 529**:

- Laboratory
- Pharmacist only visits of any kind (a pharmacist is not a core provider)
- Radiology including ultrasound

- Drugs and biologicals
- Outreach
- Case Management
- Transportation
- **Allergen Immunotherapy is not a billable visit regardless of the provider of service.**

- Visiting Nurse Services (billed under Revenue Code 522). You must be a designated HPSA Home Health Shortage Area.

- FQHC visits are not subject to Part B deductible, therefore, are treated as a third party by Montana Medicaid. The exact amount of payment (not your contractual amount) you receive from Medicare must be entered in line 54 of the UB-92. You will receive the difference between your PPS rate and the amount paid by Medicare, less any other third-party payment, co-payments or co-insurances.

FQHC SERVICE AREAS

- The FQHC clinic
- Other medical facility (may include a dental office)
- Patient's place of residence (may include a nursing facility or other institution)
- FQHC services are **not** covered when provided in a hospital setting. If your FQHC physician visits patients in a hospital setting, these must be billed under the physician's individual Medicaid number on a HCFA 1500.

FQHC SAME DAY VISITS

Encounters with more than one FQHC health professional, and multiple encounters with the same FQHC health professional on the same day at a single location constitute a single visit except when one of the following exist:

after the first encounter, the patient suffers an additional illness or injury requiring additional diagnosis or treatment; or

the patient has a medical visit and a mental health visit, or a medical visit and a dental visit or a mental health visit and a dental visit.

- The second visit and/or third visit will need to be sent to the Department for screening. If the claim meets the criteria for a same day visit, the department will force payment.

- If the second and/or third claim is sent directly to ACS (Consultec) it will duplicate out and the provider will not receive payment.

- The dental claims are self-explanatory, due to the revenue code and diagnosis, and only need to be sent to the Department to be forced.

- For mental health or medical second visits, please attach the attending physician's notes for review. The diagnoses cannot be the same for both visits.

- We will not pay for two visits if the patient is seen by the same physician for the mental health and medical diagnoses at the same time.

- Combined visits – to receive payment, the claims must represent two distinct visits and have two different diagnoses.